

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013142

STATE FILE NUMBER

APR 20 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's Name

1641

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center		d. STREET ADDRESS (If outside, give location) 424 E. Gregory Blvd.	
3. NAME OF DECEASED (Type or print) First Jake Middle Adelman Last Adelman		4. DATE OF DEATH Month 3 Day 31 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocer	
11a. FATHER'S NAME Unknown		11b. MOTHER'S MAIDEN NAME Unknown	
12a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		12b. SOCIAL SECURITY NO. —	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) Cholecystectomy		INTERVAL BETWEEN ONSET AND DEATH MINUTE 5	
DUE TO (c) Ruptured Gall Bladder		1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 586x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1958 to 3-31-59 and last saw him alive on 3-31-59 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) B. Marcus Heller, M.D.		22b. ADDRESS 409 E. 63rd	
22c. DATE SIGNED 4-1-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr. 1 1959	23c. NAME OF CEMETERY OR CREMATORY Sheffield Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS J.P. Louis Funeral Home K.C. Mo.		25. DATE RECD. BY LOCAL REG. 4-1-59	
26. REGISTRAR'S SIGNATURE Neva Trishall			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

B. Marcus Heller

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Henry Ruffington*

Licensed Embalmer No. *2756*

P. O. Address *H. C. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.